DEPARTMENT of HEALTH and HUMAN SERVICES

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Fiscal Year 2003

Indian Health Service

Justification of Estimates for Appropriations Committees

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE

INDIAN HEALTH FACILITIES

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OVERVIEW

OBJECTIVES

The objectives of the Indian Health Service (IHS) health facilities management, health care facilities construction, sanitation facilities construction, and environmental health services programs are: 1) to provide optimum availability of functional, well-maintained IHS and tribally-operated health care facilities and adequate staff housing at health care delivery locations where no suitable housing alternative is available; and 2) to reduce the incidence of environmentally-related illness and injury by: a) determining and addressing factors contributing to injuries; b) working with the tribes to improve environmental conditions; and c) constructing sanitation facilities and ensuring the availability of safe water supply and adequate waste disposal facilities in American Indian and Alaska Native (AI/AN) homes and communities.

Through the provisions of these comprehensive environmental health services and diversified construction programs, the Federal and tribal health care delivery system is enhanced and the individual home and community environments are much improved. Currently, all IHS hospitals and clinics are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The gastroenteric and postneonatal death rates among the AI/AN population have been reduced significantly now that over 85 percent of AI/AN homes have safe drinking water supplies and sanitary waste disposal systems. Injury prevention efforts of the IHS and tribal programs are also making strides to reduce outpatient visits and hospitalizations. Clearly, these program accomplishments provide significant contributions to the overall IHS health promotion/disease prevention effort.

FUNDING

The fiscal year (FY) 2002 Indian Health Facilities appropriation provided $369,487,000 for IHS facilities and environmental health activities including $46,331,000 for health care facilities maintenance and improvement activities (not including an estimated $5,700,000 in reimbursements; i.e., quarters return funds); $86,260,000 for new/replacement health care facilities construction projects; $93,827,000 for sanitation facilities construction projects; $126,775,000 for facilities and environmental health support ($63,032,000 for facilities support, $52,856,000 for environmental health support, and $10,887,000 for the Office of Environmental Health and Engineering (OEHE) Support); and $16,294,000 for Equipment. The FY 2003 Indian Health Facilities request is $370,475,000 to provide the services listed above (not including an estimated $5,900,000 in rent collections called quarters return funds to be available in FY 2003 for operation and maintenance of staff quarters).

PROGRAM DESCRIPTION

- **Maintenance and Improvement (M&I)**

  This budget activity provides resources that the IHS uses for materials and contract services needed: 1) to keep existing Federal and tribal health care facilities and grounds in good repair; 2) to perform preventive maintenance on facilities and equipment; 3) to

accomplish needed improvements to existing space so that facilities will be better suited for delivery of health care services to AI/ANs; 4) to accomplish environmental assessments and remediation of environmental problems; and 5) to demolish health care facilities replaced through Federal funding.

The FY 2002 appropriation of $46,331,000 will enable IHS to distribute approximately $27,918,000 for routine maintenance activities among all IHS and tribal contracted facilities; allocate $3,000,000 for environmental assessments and remediation, and distribute $13,913,000 for maintenance and improvement projects to address critical items from IHS' Backlog of Essential Maintenance, Alteration, and Repair (BEMAR); allocate $1,000,000 for the Northwest Portland Area AMEX program, and $500,000 to demolish vacant or obsolete health care facilities replaced through federal funding. All funds are distributed to IHS direct operated and eligible tribal facilities. These on-going activities will be continued in FY 2003 except the earmark for the AMEX program.

- **Sanitation Facilities Construction (SFC)**

This budget activity funds construction of water supply and waste disposal facilities for Indian homes and communities, as authorized by the Indian Sanitation Facilities Act, P.L. 86-121.

> The proportion of AI/AN homes with essential sanitation facilities (safe water supplies and adequate waste disposal systems) has increased from 20 to 85 percent since the program's inception in 1960. The availability of such facilities among all U.S. populations is approximately 98 percent.

The SFC program is an integral part of the IHS disease prevention initiative and tribal involvement has been the keystone of SFC program success.

> Since P.L. 86-121 was passed, the IHS has constructed community and individual water supply and waste disposal systems, which serve more than 249,000 AI/AN homes.

The appropriation of $93,827,000 in FY 2002 plus contributed funds will enable the SFC program to provide first-service to an estimated 3,800 additional new/like-new, and existing AI/AN homes; and upgrade service to 11,455 more existing homes. At congressional direction, sanitation facilities deficiencies in AI/AN communities are quantified, rank ordered and submitted annually for review. These activities will continue in FY 2003.

Most SFC projects are planned, designed, and managed by IHS engineers and constructed by tribal or non-Indian contractors. Between 75 and 90 percent of the construction is performed by Indian tribes and firms. In addition, a few self-governance tribes/organizations are now providing their own professional engineering services. Considering the extremes in climate and geography often found in Indian country, IHS engineers are uniquely challenged to design appropriate, economical, and uncomplicated facilities in order to ensure continued operation and maintenance and long-term health benefits. To further this end, after construction is complete, engineers, sanitarians, and environmental health technicians continue to provide technical

assistance and training to system operators and individual homeowners. Technical assistance and training efforts, that benefit tribal utility system managers and operators, positively affect the health and well-being of several hundred thousand AI/ANs every year by ensuring that improved water supply and waste disposal services are provided for their homes and communities.

- **Health Care Facilities Construction (HCFC)**

This budget activity funds construction, including equipment, of new and replacement inpatient and outpatient or ambulatory health care facilities (hospitals, health centers, etc.), staff quarters, and additional space at existing facilities, as required to provide direct health care services to AI/ANs.

The FY 2002 appropriation of $86,260,000 provided funding to: continue construction of the Ft. Defiance, Arizona project ($27,827,000); continue construction of the Winnebago, Nebraska hospital ($15,000,000); begin construction of the Pinon, Arizona health center ($2,600,000); begin construction of the Red Mesa, Arizona health center ($5,000,000); begin construction of the Pawnee, Oklahoma health center ($5,000,000); begin construction of the St. Paul, Alaska, health center ($2,100,000); begin construction of the Metlakatla, Alaska health center ($3,400,000); complete design of the Sisseton, South Dakota health center project; continue the Yukon-Kuskokwim Bethel, Alaska quarters project ($5,000,000); continue the Zuni, New Mexico quarters project ($2,000,000); continue the Joint Venture program ($5,000,000); continue the Small Ambulatory Facilities program ($10,000,000); and continue construction of new or replacement dental units ($1,000,000). In FY 2003 IHS will continue to fund many of the projects on the IHS Health Care Facilities Planned Construction Budget.

The need for each health care facility and staff quarter construction project is assessed through application of comprehensive priority system methodologies. Periodically, Headquarters solicits proposals from the IHS Areas for essential staff quarters needs, and urgently needed new or replacement health care facilities. The proposals are evaluated objectively and ranked according to relative need.

> Justification documents are prepared for those ranked highest and, when approved, the projects are placed on the appropriate IHS facilities priority list and funding estimates are included in the 5-year IHS Health Facilities Planned Construction Budget.

The IHS is authorized to construct health facilities by the Snyder Act, 25 U.S.C. 13; and the Indian Health Care Improvement Act, Public Law 94-437. These authorities include inpatient and outpatient facilities, staff quarters, small ambulatory facility construction grants, youth regional treatment centers, joint ventures, and dental units. Also, use of Health Services carryover funds and Medicare/Medicaid funds for construction is authorized.

- **Facilities and Environmental Health Support (F/EHS)**

This budget activity provides resources that the IHS uses to staff and support its Headquarters, Area, district, and service unit activities; i.e., facilities and environmental health activities carried out

directly by Federal employees or, in certain cases, indirectly by tribal contractors. This activity funds all costs for the permanent personnel who manage and implement the IHS health care facilities maintenance and improvement program; the health care facilities new and replacement construction program; the biomedical equipment maintenance and repair program; the sanitation facilities construction program; the environmental health services program; and the real property and health facilities planning programs. In addition, it supports personnel who operate the physical plant at IHS owned health care facilities, and certain non-personnel related operating costs (e.g., utilities).

In order to maintain clear distinction between the three major categories of costs included in this activity, the IHS has established three sub-activities: 1) Facilities Support; 2) Environmental Health Support; and 3) Office of Environmental Health and Engineering Support. These sub-activities are described separately below.

Facilities Support

This budget sub-activity funds personnel costs, at the Area and service unit levels, related to planning; justifying; designing; constructing; improving; leasing or renting; operating and maintaining IHS direct-operated (and, for certain purposes, tribal-operated) health care facilities. Also, it funds related Area and service unit operating costs; e.g., utilities, biomedical equipment repair/maintenance, some non-medical building operations, supplies (e.g., filters, fan belts, etc.), and some non-clinical personal property.

The IHS, tribes, and tribal groups operate hospitals, health centers, school health centers, smaller health stations and satellite clinics, youth regional substance abuse treatment centers (YRTC), alcohol and substance abuse program (ASAP) facilities, and staff quarters.

The IHS owns approximately 853 000 square meters of Federal space in hospitals, clinics, staff quarters, and other facilities. In addition, health care delivery and administrative program elements are provided in space leased from Tribes (99 000 square meters) and in GSA assigned space (61 000 square meters).

The tribes operate health care delivery and administrative program elements in approximately 409 000 square meters of space of which all but approximately 41 000 square meters is owned by the tribes.

Environmental Health Support

This budget sub-activity funds personnel costs, at the Area, district, and service unit levels, related to providing environmental health services, including injury prevention, to the AI/AN people, to their communities, and to government (tribal, IHS, Bureau of Indian Affairs (BIA), local, etc.) institutions. Also, it funds permanent personnel costs, at the Area, district, and service unit levels, for planning, designing, and constructing Indian sanitation facilities and providing follow-up technical support and training to AI/AN owners and operators of those systems. In addition, it funds community-based environmental health activities including rabies vaccination clinics, vector control efforts, such as plague and Hanta virus surveillance activities, and

targeted community hazard evaluations such as radon monitoring, lead based paint surveys and community environmental health assessments. Funds are also used for targeted community injury prevention projects and the development of tribal infrastructure to address identified community injury problems.

In FY 2002, environmental health services provided by IHS Area, district, and service unit environmental health personnel will include such activities as: injury prevention, epidemiological studies, water supply monitoring, vector control activities, food protection surveys, waste disposal investigations/technical assistance, institutional environmental health, and safety evaluations of diagnostic radiographic imaging devices. These activities are continued in the FY 2003 request.

Especially noteworthy are environmental health services provided in the injury prevention category.

> The IHS environmental health staff has lead responsibility for coordinating development and implementation of community-based prevention measures to address the problem of injuries, which is the leading killer of AI/ANs age 0 to 44 years.

An encouraging downward trend in injury death rates for AI/ANs is being achieved as a result of this increased attention. Given these successes, the IHS has implemented a 5-year Indian Injury Prevention Plan (Immunizing Against the Injury Epidemic).

Once completed, sanitation projects initiated in FY 2002 will provide essential sanitation facilities to 450 new, HUD-sponsored housing units, 290 BIA-sponsored units, 3,060 units constructed by tribes and other entities, and 1,795 first service existing homes (total: 5,595 first service housing units). In conjunction with providing sanitation facilities for the first time to the homes listed above, sanitation systems serving 9,660 previously served (existing) homes are to be upgraded.

Office of Environmental Health and Engineering (OEHE) Support

This budget sub-activity is used to fund personnel costs, at IHS Headquarters including the Division of Engineering Services (ES) at two locations, for direct support/management of the full array of services and activities funded by the Facilities appropriation.

The engineers, architects, sanitarians, health facilities planners, leasing/contract specialists, real property managers, and support personnel who work in Headquarters provide technical and management services required to design, construct, operate, and maintain efficient, accessible, and serviceable health care facilities and staff quarters; address IHS leasing/rental requirements; provide appropriate injury prevention and environmental health services and construct sanitation facilities for Indian homes and communities; meet all legal and policy requirements for financial and program accountability; and develop long-range staffing and programmatic goals to ensure continued program effectiveness.

In FY 2002, OEHE Headquarters and ES staff will complete engineering technical reports, surveys, and studies; prepare mandated reports to Congress; award major health care facility design/construction contracts including modifications; process IHS and GSA leases; hold tribal and Federal employee training courses to address staff development and retention issues; and manage active health care facilities design/construction projects.

- **Equipment**

  This budget activity funds the purchase and replacement of medical equipment for Federal and tribal health care facilities.

  In FY 1995, Congress created this activity to consolidate funds for medical equipment in the Facilities appropriation. The current IHS medical equipment inventory is approximately $310 million. Of the $16,294,000 final appropriation in FY 2002, $10,794,000 will be used to address sustaining this inventory by replacement of medical equipment, including purchase of DOD equipment by the IHS for IHS and tribal facilities; $500,000 will be used to replace tribal ambulances, and $5,000,000 will be used to provide equipment for new tribally built health facility space. These activities will continue in the FY 2003 request.

INDIAN HEALTH FACILITIES
Summary of Budget Request

	2001 Actual	2002 Appropriation	2003 Estimate	Increase OR Decrease
Current Law BA.....	$363,103,000	$369,487,000	$362,571,000	-$6,916,000
Accrued Costs.....	7,020,000	7,531,000	7,904,000	373,000
Proposed Law BA.....	$370,123,000	$377,018,000	$370,475,000	-$6,543,000
FTE.....	1,260	1,268	1,286	+18

The FY 2003 budget request of $370,475,000 (including accrual cost of $7,904,000) and 1,286 is a decrease of $6,543,000 and an increase of 18 FTE over the FY 2002 Enacted level of $369,487,000 plus accrued cost of $7,531,000 and 1,268 FTE.

FY 2002 Current Services: +$6,717,000 and 18 FTE

The IHS is requesting an increase of $6,717,000 for Current Services which includes funding for pay raises, Tribal Pay Cost, inflation, new staffing and related operating costs for new facilities. The current services increase includes the following:

- $3,336,000 for pay related cost.
- $875,000 Inflation Tribal Pay Cost
- $2,311,000 and 18 FTE for Phasing-In of Staffing and Operating Cost for new facilities.

Program Changes: -$13,260,000

- +$1,000,000 for maintenance and improvement of health care facilities
- -$14,260,000 for new/replacement health care facilities construction.

Accrued Retirement and Health Benefits Costs

The increase of $373,000 is associated with the proposed Managerial Flexibility Act of 2001; **the full accrued cost in FY 2003 for Facilities is $7,904,000.** This legislation requires agencies, beginning in FY 2003, to pay the full Government share of the accruing cost of retirement for current CSRS, CIA and Foreign Service employees, and the Coast Guard, Public Health Service and NOAA Commissioned Corps. The legislation also requires agencies to the pay full accruing cost of post-retirement health benefits for current civilian employees. The intention of the legislation is to budget and present the full costs of Federal employees in the accounts and programs where they are employed. This legislation is part of an initiative to link budget and management decisions to performance by showing the full cost of each year's program operations together with the output produced that year. These accrual costs are shown comparably in FY 2001 and FY 2002.

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ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Indian Health Service
Indian Health Facilities - 75-0391-0-1-551
Maintenance and Improvement

Program Authorization: Program authorized by U.S.C. 13, Snyder Act and Public Law 83-568, Transfer Act 42 U.S.C., 2001.

	2001 Actual	2002 Appropriation	2003 Estimate	Increase or Decrease
Budget Authority..	$46,331,000	$46,331,000	$47,331,000	+$1,000,000

PURPOSE AND METHOD OF OPERATION

The Indian Health Service (IHS) maintains Federal government owned buildings and supports maintenance and improvement activities where tribally owned space is used to provide health care services pursuant to contract or compact arrangements executed under the provisions of the Indian Self Determination and Education Assistance Act (P.L. 93-638). The Maintenance and Improvement (M&I) program objectives include: (1) providing routine maintenance for facilities; (2) achieving compliance with buildings and grounds accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other applicable accreditation bodies; (3) providing improved facilities for patient care; (4) ensuring that health care facilities meet building codes and standards; and (5) ensuring compliance with executive orders and public laws relative to building requirements, e.g. energy conservation, seismic, environmental, handicapped accessibility, and security.

The IHS Facilities Engineering Plan (FEP) establishes annual M&I workload targets and helps determine the most prudent use of available resources. The FEP is prepared by IHS Areas, service units, and tribal personnel to identify; delineate, and plan facilities related activities and projects to be accomplished during an upcoming fiscal year for the M&I program.

Funds in the M&I account are used primarily to maintain and improve health care facilities. Staff quarters operation, maintenance, and improvement costs are primarily funded with rent collections called Quarters Return (QR) funds. The M&I funds may be used in conjunction with QR funds at locations with few quarters or where QR funds are insufficient to ensure appropriate maintenance.

Status of Facilities:

The physical condition of IHS-owned and most tribally owned facilities is evaluated through annual general surveys conducted by local facility personnel and IHS Area engineers. In addition, comprehensive "Deep Look" surveys are conducted every 5 years by a team of engineers and architects.

These surveys, together with routine observations by facilities personnel, identify deficiencies that are included in the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) database. The identified BEMAR for IHS and reporting tribal facilities as of December 2001 is $484,780,000.

The following table summarizes the BEMAR by category:

BEMAR 1/

PUBLIC LAW	
Life Safety Compliance	$43,071,000
General Safety	8,841,000
Environmental Compliance	25,131,000
Handicapped Compliance	16,526,000
Energy Conservation	11,375,000
Seismic Mitigation	109,717,000
Sub Total	$214,661,000
IMPROVEMENTS	
Patient Care	18,181,000
Program Deficiencies	13,649,000
Sub Total	$131,830,000
MAINTENANCE & REPAIR	
Architectural M&R	8,417,000
Structural M&R	35,238,000
Mechanical M&R	48,467,000
Electrical M&R	21,413,000
Utilities M&R	4,650,000
Grounds M&R	16,607,000
Painting M&R	2,013,000
Roof M&R	1,504,000
Sub Total	$138,309,000
GRAND TOTAL	**$484,780,000**

1/ The FY 2002 M&I allocation will be distributed for routine maintenance and projects; these projects reduce identified BEMAR deficiencies.

2/ The Earthquake Hazard Reduction Program Act required IHS to survey and estimate the cost associated with compliance to seismic construction standards. This survey was completed in the Fall of 1998 and added $149,127,000 in seismic deficiencies. Some Areas have chosen to exclude low seismic hazard zones, which have subsequently reduced the number.

3/ Staff quarters operation, maintenance, and improvement costs are funded through rents collected, called Quarters Return (QR) funds. The M&I funds may be used in conjunction with QR funds at locations where QR funds are insufficient to ensure appropriate quarters maintenance.

4/ Projects include air quality improvement, asbestos remediation, and contaminated soil remediation. This work is continuing and the assessments have identified significant additional funding requirements for environmental remediation, approximately $7.2 million in costs were added this past year.

DISTRIBUTION OF M&I FUNDS

Current Distribution Method

The IHS M&I funds are distributed to four subprograms, routine maintenance, M&I projects, environmental compliance, and demolition:

Routine Maintenance Funds - Amounts are calculated using the IHS M&I distribution formula, which is based on the University of Oklahoma methodology to calculate routine maintenance funds. Routine M&I funds can be used to pay non-personnel costs for the following activities in IHS and tribally-owned health care facilities: maintenance supplies and materials, preventive maintenance activities, emergency repairs, building service equipment replacement, upkeep activities, training, and local projects.

M&I Project Funds - Amounts are calculated using the IHS M&I distribution formula. The IHS Area Facilities Engineers develop priority lists of large projects to reduce the BEMAR. Generally M&I projects in this subprogram require levels of expertise not available at the local facility. Such projects accomplish major repairs and improvements of primary mechanical, electrical, and other building systems as well as public law compliance and program-related alterations. Program-related alteration projects include changes to existing facilities for more efficient utilization, for new patient care equipment, and for new treatment methodologies.

Environmental Compliance Funds - Many IHS and tribal facilities were constructed before the existence of current environmental laws and regulations. Since we are required to comply with current Federal, State, and local environmental regulations, the use of environmental assessments to identify and evaluate potential environmental hazards is important. These assessments form the basis of the IHS facilities environmental remediation plan. The IHS has identified approximately $25,131,000 in environmental compliance tasks and included them in the BEMAR database. Tribally owned health care facilities can receive assessments upon request by the tribe.

Demolition Funds - The IHS has a number of buildings that are vacant or obsolete and no longer needed. The number currently is estimated at 20-25 buildings. Many of these buildings are safety and security hazards. Demolition of these buildings reduces hazards and liability.

FUTURE FACILITIES ISSUES

Several issues have future impact on the ability for IHS to continue to maintain and operate health care facilities. The number of new requirements associated with programs for seismic safety of facilities has increased significantly, although low seismic zones are no longer included. The IHS provided a seismic report to the Federal Emergency Management Agency (FEMA) in December 1998. Modifications to IHS Federally-owned and leased facilities needed to comply with seismic construction requirements total more than $149 million for all seismic zones and approximately $110 million for high and medium seismic zones.

In addition, numerous tribal and some Federal buildings are added each year to the inventory that require maintenance and improvement funding. These additional buildings further dilute the amount of funds available at each site. Environmental issues, as noted previously, continue to expand and new issues such as lead paint removal have a substantial impact on renovation of older IHS facilities.

Steady State Condition -

The Building Research Board of the National Academy of Sciences (NAS) (*Committing to the Cost of Ownership - Maintenance and Repair of Public Buildings, 1990*) has determined that approximately 2 to 4 percent of current replacement value of supported buildings is required to maintain facilities in their current condition.

This amount would not render a net reduction in existing BEMAR and would not include improvements and alterations nor include staff and utilities operating costs.

The current (2001) replacement value, of all M&I eligible facilities, is approximately $1.859 billion.

Funding levels for the past 5 years are as follows:

Year	Funding
1998	$39,334,000
1999	$40,625,000
2000	$43,433,000
2001	$46,331,000
2002	$46,331,000

Accomplishments

A total of $46,331,000 was appropriated in FY 2001 plus approximately $5,500,000 in quarters return funds was distributed. The M&I funds were used for: (1) routine maintenance and projects - approximately $27,918,000 was provided to the IHS Areas for daily maintenance activities and projects to maintain the current state of health care facilities; approximately $13,913,000 was provided to the IHS areas to reduce the identified Backlog of essential Maintenance, Alterations, and Repair (BEMAR); (2) Environmental Compliance - approximately $3,000,000 was provided for environmental assessments and environmental remediation projects; (3) allocate $1,000,000 for the Northwest Portland Area AMEX program; and demolition - approximately $500,000 was provided to demolish vacant or obsolete health care facilities replaced through Federal funding. These on-going activities will be continued in FY 2003 except the earmark for the AMEX program which will be re-allocated to the M&I base for general distribution.

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST - The request of $47,331,000 is an increase of $1,000,000 above the FY 2002 Enacted level of $46,331,000. This increase will address the following:

Maintenance & Improvement - +$1,000,000

This increase will provide funding to address the need to maintain additional space added to the health care facilities inventory through new construction appropriations or through tribal funded supportable space.

ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Indian Health Service
Indian Health Facilities - 75-0391-0-1-551
Sanitation Facilities

Program Authorization: Program authorized by U.S.C. 13 Snyder Act, PL 83-568, Transfer Act, 42 U.S.C. 2001, PL 86-121, Indian Sanitation Facilities Act; and Title III of PL 94-437, Indian Health Care Improvement Act, as amended.

	2001 Actual	2002 Appropriation	2003 Estimate	Increase or Decrease
Current Law BA.....	$93,617,000	$93,827,000	$93,983,000	+$156,000
Accrued Costs 1/...	1,091,000	1,163,000	1,202,000	39,000
Proposed Law BA....	$94,708,000	$94,990,000	$95,185,000	+$195,000
FTE.....	195	195	195	--

Number of Homes Benefited

	2001 Actual	2002 Appropriation	FY 2003 Estimate
	Fiscal Year Program		
A. New/Like-New			
HUD.....	483 1/	450 1/	450 1/
BIA/HIP.....	227	290	290
Tribal/Other.....	2,841	3,060	3,060
Subtotal.....	3,551	3,800	3,800
B. Existing Indian Homes			
First Service.....	1,646	1,795	1,795
Upgraded/Emergency.....	12,805	9,660	9,660
Subtotal.....	14,451	11,455	11,455
TOTAL.....	18,002 2/	15,255 2/	15,255 2/

1/ Sanitation Facilities to be funded with HUD grants contributed by tribes to IHS projects.
2/ Construction projects are funded with IHS appropriated funds and contributions to serve these homes.

1/ Please see Exhibit S for the crosswalk from current law to proposed law to reflect the Administration's proposal for full retirement and health benefits.

PURPOSE AND METHOD OF OPERATION

The Indian Sanitation Facilities Act, P.L. 86-121, authorizes IHS to provide essential sanitation facilities to Indian homes and communities.

The IHS Sanitation Facilities Construction Program, an integral component of the IHS disease prevention activity, has carried out those authorities since 1960 using funds appropriated for Sanitation Facilities Construction to provide potable water and waste disposal facilities for AI/AN people. As a result, the rates for infant mortality, the mortality rate for gastroenteritis and other environmentally related diseases have been dramatically reduced, by about 80 percent since 1973. The IHS physicians and health professionals credit many of these health status improvements to IHS' provision of water supplies, sewage disposal facilities, development

of solid waste sites, and provision of technical assistance to Indian water and sewer utility organizations.

A Report to Congress by the Comptroller General (dated March 11, 1974) noted that AI/AN families living in homes with satisfactory environmental conditions placed fewer demands on IHS' primary health care delivery system than families living in homes with unsatisfactory conditions; i.e., those with satisfactory environmental conditions in their homes (e.g., safe piped water and adequate sewage disposal) required approximately 25 percent of the health care services required by those with unsatisfactory environmental conditions.

The provision of Indian sanitation facilities is a very important component of the overall effort required to achieve a reduction in infant mortality, a goal highlighted in Healthy People 2010 "The Year 2010 Objectives for the Nation." Safe drinking water supplies and adequate waste disposal facilities are essential preconditions for most health promotion and disease prevention efforts, as well as being a major factor in the quality of life of Indian people.

Currently, about 1 percent of all U.S. homes lack safe water in the home while about 7.5 percent (approximately 21,000) of all AI/AN homes lack safe water in the home.

Support for the IHS' justification of Sanitation Facilities Construction Program funding can be found in a PHS study entitled "Relationship of Environmental Factors to the Occurrence of Enteric Disease in Areas of Eastern Kentucky." The data support the premise that the incidence of acute infections and diarrhea disease could be reduced significantly by selectively modifying environmental factors. The IHS physicians have stated that the Indian Sanitation Facilities Act has had a greater positive effect upon the health of AI/ANs than any other single piece of legislation.

As with other IHS activities, sanitation facilities projects are carried out cooperatively with the Indian people who are to be served by the completed facilities. Tribal involvement has been the keystone of the Sanitation Facilities Program since its inception in FY 1960. Projects are initiated only following receipt of a tribal request expressing willingness on their part to participate in carrying out the project and willingness to execute an agreement to assume ownership responsibilities, including operation and maintenance, for completed facilities.

With completion of all projects approved through FY 2001, approximately 249,000 AI/AN homes will have been provided sanitation facilities since 1960. Experience shows that 60 to 70 percent of the actual construction is performed by Indian tribes/firms.

Sanitation Facilities Needs

The Indian Health Care Improvement Act (Title III, Section 302(g) 1 and 2 of P.L. 94-437) directed the IHS to identify the universe of Indian sanitation facilities needs for existing Indian homes. As of the end of FY 2001, the list of all documented projects totaled $1.6 billion with those projects considered economically feasible totaling $876 million. In FY 2001, of the $93,617,000 appropriated for sanitation facilities, $46,409,000 was used to address the backlog of existing homes including $4.7 million to serve solid waste needs (included in the solid waste

funding was $500,000 to clean up open dumps identified by an interagency task force, the members of which included the Bureau of Indian Affairs, the Environmental Protection Agency, the Department of Agriculture and others). The remainder of the FY 2001 appropriation was used to provide $264,500 for special projects, $326,500 for emergency projects, and $46,617,000 was used for sanitation facilities for new/like-new Indian homes.

As proposed, the current backlog of projects would provide sanitation facilities to between 95 and 98 percent of all existing Indian homes. Also included in the backlog are projects intended to upgrade existing water supply and waste disposal facilities and projects to improve sanitation facilities operation and maintenance capabilities in Indian country. Maximum health benefits will be realized by addressing existing sanitation needs identified in the backlog and also by providing sanitation facilities for new homes when they are constructed.

Funding levels for the last 5 fiscal years follows:

Year	Funding	FTE
1998	$89,082,000	244
1999	$89,328,000	244
2000	$92,117,000	197
2001	$93,617,000	195
2002	$93,827,000	195

DISTRIBUTION OF SANITATION FACILITIES CONSTRUCTION FUNDS

The FY 2003 Sanitation Facilities Construction portion of the appropriation will be allocated as follows:

1) $500,000 will be reserved at IHS Headquarters for distribution to the Areas as needed to address water supply and waste disposal emergencies caused by natural disasters or other unanticipated situations that require immediate attention to minimize potential threats to public health. Emergency funds remaining at the end of the fiscal year will be distributed to the Areas to address the Sanitation Deficiency System (SDS) priority list of needs.

2) Up to $47,000,000 of the total FY 2003 sanitation facilities construction appropriation will be reserved to serve new and like-new homes. Some of these funds may also be used for sanitation facilities for the individual homes of the disabled or sick that have physician referrals indicating an immediate medical need for adequate sanitation facilities in their home. As needed, amounts to serve new and like-new homes will be established by Headquarters after reviewing Area requests. Priority will be given to projects intended to provide sanitation facilities for the first time to homes in categories B, C, and D (new homes and homes receiving major renovation bringing the homes up to like new condition) under the BIA Housing Improvement Program (HIP). (NOTE: Homes in BIA/HIP Category A are considered existing homes. Category A homes needing service will be included in the SDS.)

   The amount allocated to each Area for projects to serve other new/like-new homes will be the Area's pro-rata share of remaining funds for serving such housing.

3) Up to $5,000,000 will be used for projects to clean up and replace open dumps on Indian lands pursuant to the Indian Lands Open Dump Cleanup Act of 1994.

4) The balance of the amount appropriated in FY 2003 will be distributed to the Areas for prioritized projects to serve existing homes, based on a formula that considers, among other factors, the cost of facilities to serve existing homes that: a) have not received sanitation facilities for the first time; or b) are served by substandard sanitation facilities (water and/or sewer). Another distribution formula element is a weight factor that favors Areas with larger numbers of AI/AN homes without water supply or sewer facilities, or without both.

The IHS appropriated funds will not be used to provide sanitation facilities for new homes funded with grants by the housing programs of the Department of Housing and Urban Development (DHUD). These DHUD housing grant programs for new homes are able to fund the sanitation facilities necessary for the homes.

ACCOMPLISHMENTS

Sanitation Facilities Construction (SFC) - The FY 2001 accomplishments are as follows: (1) received over $44.0 million in SFC contributions from other Federal agencies, States, and Tribes. Combined with SFC appropriation, the total SFC program funded 456 projects in FY 2001; (2) the staff also provided engineering services to many other Tribes that independently funded their own projects; (3) provided essential sanitation facilities to 18,002 Indian homes (3,551 new or like-new homes and 14,451 existing homes) with water, sewage disposal, and/or solid waste facilities.

Performance Measures

The following performance indicator is included in the IHS FY 2003 Annual Performance Plan. These indicators are sentinel indicators representative of some of the more significant health problems affecting AI/AN. At the FY 2003 funding level, IHS could accomplish the following:

Indicator 35: During FY 2003, provide sanitation facilities projects to 15,255 Indian homes (estimated 3,800 new or like-new homes and 11,455 existing homes) with water, sewage disposal, and/or solid waste facilities.

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST - The FY 2003 request of $95,185,000 (including accrued costs of $1,202,000) and 195 FTE is an increase of $195,000 over the FY 2002 enacted level of $93,827,000 plus accrued cost of $1,163,000 and 195 FTE. The increase includes the following:

Pay Cost Increases: +$195,000

The request of $195,000 for Federal pay costs will partially fund the increase cost of providing sanitation facilities to IHS beneficiaries and other built-in cost increases associated with on-going projects. Included are increases such as the FY 2003 pay raise, within grade increases, increased cost of equipment, contracts, etc.

Accrued Retirement and Health Benefits Costs

The increase of $39,000 is associated with the proposed Managerial Flexibility Act of 2001; **the full accrued cost in FY 2003 for Facilities is $1,202,000.** This legislation requires agencies, beginning in FY 2003, to pay the full Government share of the accruing cost of retirement for current CSRS, CIA and Foreign Service employees, and the Coast Guard,

Public Health Service and NOAA Commissioned Corps. The legislation also requires agencies to the pay full accruing cost of post-retirement health benefits for current civilian employees. The intention of the legislation is to budget and present the full costs of Federal employees in the accounts and programs where they are employed. This legislation is part of an initiative to link budget and management decisions to performance by showing the full cost of each year's program operations together with the output produced that year. These accrual costs are shown comparably in FY 2001 and FY 2002.

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ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Indian Health Service
Indian Health Facilities - 75-0391-0-1-551
Health Care Facilities Construction

Program Authorization: Program authorized by U.S.C. 13 Snyder Act, P.L. 83-568, Transfer Act, 42 U.S.C. 2001, P.L. 94-437, Indian Health Care Improvement Act, as amended, P.L. 99-570, Omnibus Drug Bill.

	2001 Enacted	2002 Appropriation	2003 Estimate	Increase Or Decrease
Program Output Data:				
Inpatient (Hospitals):				
Ft. Defiance,AZ.....	$40,026,000	$27,827,000	$20,400,000	N/A
Winnebago, NE.....	12,259,000	15,000,000	8,241,000	N/A
Total Inpatient.....	**$52,285,000**	**$42,827,000**	**$28,641,000**	**-$14,186,000**
Outpatient (Health Centers):				
Parker, AZ.....	$8,310,000	$ 0	$ 0	N/A
Pinon, AZ.....	0	2,600,000	13,900,000	N/A
Red Mesa, AZ.....	0	5,000,000	7,653,000	N/A
Pawnee, OK.....	1,741,000	5,000,000	10,639,000	N/A
St. Paul, AK.....	0	2,100,000	11,167,000	N/A
Metlakatla, AK.....	0	3,400,000	0	N/A
Sisseton, SD.....	0	2,333,000	0	N/A
Total Outpatient.....	**$10,051,000**	**$20,433,000**	**$43,359,000**	**+$22,926,000**
Staff Quarters:				
Bethel, AK.....	$ 4,989,000	$ 5,000,000	$ 0	N/A
Zuni, NM.....	0	2,000,000	0	N/A
Total Staff Qtrs.....	**$ 4,989,000**	**$7,000,000**	**$ 0**	**-$7,000,000**
Joint Venture Const. Program.....	**$ 4,989,000**	**$ 5,000,000**	**$ 0**	**-$5,000,000**
Small Ambulatory Program.....	**$ 9,978,000**	**$10,000,000**	**$ 0**	**-$10,000,000**
Dental Units.....	**$ 998,000**	**$ 1,000,000**	**$ 0**	**-$1,000,000**
Special Project: Polacca (Hopi),AZ Quarters Assist.....	**$ 2,235,000**	**$ 0**	**$ 0**	**0**
TOTAL.....	**$85,525,000**	**$86,260,000**	**$72,000,000**	**-$14,260,000**

The inpatient and outpatient health care facilities and staff quarters projects are shown in priority order but they are not prioritized against other identified activities that are listed. For example, the Bethel, AK, staff quarters project does not have a higher priority than the Joint Venture Construction Program.

PURPOSE AND METHOD OF OPERATION

The objectives of the Indian Health Service (IHS) Health Care Facilities Construction Program are to enhance IHS health care delivery capacity by providing for optimum availability of functional, well-maintained IHS and tribally-operated health care facilities and providing staff housing at IHS health care delivery locations if no suitable housing alternative is available. The IHS capital improvement program, funded through this budget activity, is authorized to construct health care facilities and staff quarters, administer the IHS/Tribal Joint Venture Construction Program, renovate/construct Youth Regional Treatment Centers for substance abuse, provide construction funding for small ambulatory care facilities, replace/provide new dental units, and to assist non-IHS funded renovation projects.

To determine the locations where new and replacement facilities are most critically needed, the IHS has developed and is implementing comprehensive priority system methodologies for health care facilities and staff quarters construction. As needed, IHS Headquarters solicits proposals from the IHS Areas for essential staff quarters projects, replacement/new dental units, and for urgently needed new or replacement health care facilities. These proposals are evaluated and prioritized. Formal justification documents are prepared for those scoring highest. Once justified, projects are placed on the appropriate construction priority list and proposed for funding.

Health Care Facilities Construction Program

During FY 1990, in consultation with the tribes, the IHS revised its Health Facilities Construction Priority System (HFCPS) methodology. The HFCPS ranks proposals using factors reflecting the total amount of space needed; age and condition of the existing facility, if any; degree of the isolation of population to be served in the proposed facility; and availability of alternate health care resources. There are three phases to the HFCPS. During FY 1991, Phase I of the methodology was applied to 149 IHS Area-generated proposals to construct new or replacement health care facilities. Based on the Phase I result, the IHS proceeded with Phase II of the methodology, using a more detailed analysis of the 28 highest ranked proposals. During FY 1992, the IHS consulted with tribes about incorporating additional flexibility into the HFCPS in order to give consideration to new concepts, such as low acuity beds in health centers, as directed by the Congress in the FY 1992 Conference Report on IHS appropriations. Few tribes urged the IHS to make changes to the HFCPS. In FY 1993, 23 of the 28 proposals considered in Phase II were advanced to Phase III. IHS Area Offices were asked to develop Program Justification Documents (PJDs) for each of the 23 proposed facilities. As PJDs are approved, projects are added to the Health Facilities Construction Priority Lists. The IHS is still requesting funding for projects that were part of the 23 proposals in FY 1993.

The IHS has two processes for reviewing the staff housing needs. Under the Quarters Construction Priority System methodology, the IHS reviews the need for additional quarters at all existing health care facilities. Phases I and II of this methodology were last applied in 1991. As the Program Justification Document for Quarters (PJDQ) are completed for these projects, they are added to the Quarters Construction Priority List. The second process responds to the Department of Health and Human Services Office of the Inspector General report of April 17, 1990, regarding needed improvements for planning and construction of IHS staff housing. The IHS began reviewing the need for quarters at each location where new or replacement health care facilities are being planned.

Where quarters are required, IHS completes a PJDQ as a part of the PJD for the health care facility and the staff quarters need is included with facilities construction projects on the Health Care Facilities Construction Priority List.

The Department of the Interior and Related Agencies Appropriations Act for FY 1991 (P.L. 101-512) authorized and partially funded a "joint venture demonstration program to equip, supply, operate, and maintain up to three health centers." These health centers were to be "selected on a competitive basis from those tribal applicants agreeing to provide an appropriate facility for use as a health center for a minimum of 20 years, under a no cost lease." The costs of facility construction are borne by participating tribes. The IHS is responsible for requesting all costs associated with staffing, equipping, and operating the facilities. This authority was re-designated as Section 818(e) and further amended by the 1992 amendments to Public Law 94-437, the Indian Health Care Improvement Act (IHCIA).

The IHS is authorized to construct Youth Regional Treatment Centers (YRTCs) by section 704 of the IHCIA, P.L. 94-437, as amended. A YRTC is to be constructed in each IHS Area except that two each are to be constructed in California and Alaska to provide substance abuse treatment to Indian youth.

The IHS is authorized to award construction funding to tribes or tribal organizations by section 306 of the IHCIA, P.L. 94-437, as amended. Funding may be awarded only to tribes operating non-IHS outpatient facilities under P.L. 93-638 contracts. This is known as the IHS Small Ambulatory Program.

The IHS is authorized to accept renovations and modernizations of any Service facility through non-IHS funded sources and to assist by providing equipment and personnel by section 305 of the IHCIA, P.L. 94-437, as amended.

Appropriations for IHS in FY 1994-2002 included funding to replace and build new dental units.

Funding levels for the last 5 fiscal years follows:

Year	Funding
1998	$41,400,000
1999	$41,087,000
2000	$50,393,000
2001	$85,525,000
2002	$86,260,000

ACCOMPLISHMENTS

With the current funding available since 1998, per the Economic Development Administration, Department of Commerce, the $305,000,000 expended on construction projects has resulted in a positive impact of providing approximately 9,000 new jobs into the economy with 4,000 of these jobs directly involved in the construction of health facilities. Experience with health facilities construction contracts indicates that approximately one fourth of the construction labor force is Native American and approximately 1,300 jobs have been provided to residents of Indian reservations.

In FY 2001, the following were accomplished:

(1) For the Fort Defiance, Arizona, replacement hospital project, the appropriated $40,026,000 was used to continue construction of the replacement hospital portion of the project and to start design and construction of the staff quarters portion of the project.

(2) For the Winnebago, Nebraska, replacement hospital project, the appropriated $12,259,000 was used to continue construction.

(3) For the new Hopi Health Center in Polacca, Arizona, the appropriated $2,235,000 was used to reduce the debt incurred by the Hopi Tribe in providing staff quarters needed to support the new health center.

(4) The appropriated $8,310,000 for the replacement Parker Health Center, Parker, Arizona, was used to complete the construction of the facility in November 2001.

(5) The $1,741,000 appropriated for the new health center in Pawnee, Oklahoma, was used for project design.

(6) The $4,989,000 appropriated for the Bethel, Alaska staff quarters project was used to fund the project agreement between the IHS and the Yukon-Kuskokwim Health Corporation to construct staff quarters.

(7) The $4,989,000 appropriated for the Joint Venture Construction Program has been allocated for equipment procurement for two tribal projects selected for the program.

(8) The $9,978,000 appropriated for the Small Ambulatory Program will be awarded in FY 2002 through P.L. 93-638 contracts, upon the completion of competitive selections.

(9) The $998,000 appropriated for the dental units construction program was added to funds previously appropriated and allowed two additional dental units to be processed for design and construction Mariposa, California and Schurz, Nevada).

Performance Measures

The following performance indicator is included in the IHS 2003 Annual Performance Plan. This indicator is a sentinel indicator representing some of the more significant health problems affecting AI/AN. At the FY 2003 funding level, IHS could achieve the following:

Indicator 36: During FY 2003, increase the modern health care delivery system to improve access and efficiency of health care by construction of the following health care facilities:

Inpatient:

Ft. Defiance, AZ - continue construction of staff quarters associated with new replacement hospital.

Winnebago, NE - continue construction of a replacement hospital.

Outpatient:

Pinon, AZ - continue construction of a new health center, including supporting staff quarters.

Red Mesa, AZ - continue construction of a new health center, including supporting staff quarters.

Pawnee, OK - continue construction of a replacement health center.

St. Paul, AK - continue construction of a replacement tribal health center, including supporting staff quarters.

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST - The FY 2003 request of $72,000,000 is a decrease of $14,260,000 from the FY 2002 Enacted level of $86,260,000. Major projects are listed as follows:

Replacement Hospital in Fort Defiance, AZ: +$20,400,000

Funds in this request will be used to complete project funding, which will allow the completion of the staff quarters needed to support the replacement hospital project in Fort Defiance, Arizona. The replacement hospital is scheduled to open this summer.

This project is located in The Navajo Nation in Fort Defiance, Arizona. The replacement IHS health care facility will provide a comprehensive health care program, having limited inpatient services for gynecological and general ambulatory surgery, obstetrical, pediatric, intensive care, labor and delivery, and for adolescent psychiatric nursing; plus a full range of non-specialty ambulatory care, community health, dental, and associated support services. The acute care program will have 36 beds, which consists of 12 for medical/surgical, 4 for ICU/CCU, 8 for pediatrics, 7 for obstetrical, and 5 for labor/delivery/recovery/post partum. An additional, 20 beds will be used by the adolescent psychiatric nursing unit.

A total of 193 staff quarters units are needed and part of this project to support the projected non-local staff increases. Thirteen existing unsuitable units will be replaced, and 180 additional units will be provided. The use of existing housing sites will continue, and additional housing will be located next to the replacement hospital.

The existing main hospital building, being a historically structure that was constructed in 1938, cannot be altered. Even though renovations were made in 1972 and 1977, the current 49-bed hospital, which has been converted from the original 136-bed unit, is functionally inadequate to support the health care needs of the user population. Patient care and

support services are currently provided in limited spaces in the main building and eight additional separate buildings. There is no room on the present site for additional construction and the adjacent land is not available. Therefore, the only option is to provide a replacement facility on a new site.

Replacement Hospital in Winnebago, NE: +$8,241,000

Funds in this request will be used to complete construction of the replacement Winnebago hospital project.

The replacement IHS health care facility will incorporate all inpatient, birthing center, diagnostic, ambulatory, community health, administrative and support services into one structure. It will consist of 9 162 gross square meters (GSM) of new space and 1 505 GSM of renovated space in the existing facility for the expanded Drug Dependency Unit (DDU) program. Remaining temporary and permanent structures on the site will be demolished.

The existing IHS hospital built in Winnebago in 1932, cannot support the needs of the service population. The original hospital was constructed as a 40-bed, full-service inpatient facility with surgery, labor/delivery, and ambulatory services. Other permanent structures include a garage, a garage/warehouse, and an apartment unit. Temporary buildings, designed with minimum space allowances, were also added for offices, outpatient exam and emergency/urgent care rooms.

Due primarily to accreditation criteria and inadequate support space, the original planned services have been scaled down to the current 30-bed capacity with 12 beds dedicated to the DDU. Four departments (Community Health Services, Dental Services, Property and Supply, and Facilities Management) are located outside the hospital proper, in buildings on or near the hospital campus. The existing hospital and other buildings are not large enough to house the proposed health care program. Scattered existing structures and lack of space within existing buildings compromise inderdepartmental relationships.

Health Center in Pinon, AZ: +$13,900,000

Funds in this request will be used to continue construction of the new health center project in Pinon, Arizona.

The proposed new IHS health center will provide a full range of ambulatory care, as well as, comprehensive community health programs, which will address the curative and preventive health concerns for this region. This project includes 62 staff quarters units to provide adequate housing for non-local staff at this remote location.

The IHS currently provides limited basic medical services from a health station that was built in 1959 in Pinon, Arizona. With the nearest IHS health care facility located over 75 kilometers from the center of Pinon, the current program does not support the needs of the service population. The functional inadequacies of the existing building and site constraints preclude expansion at the existing site.

Health Center in Red Mesa, AZ: +$7,653,000

Funds in this request will be used to continue construction of the new health center project in Red Mesa, Arizona.

The proposed new IHS health center will provide space to support a modern and adequately staffed health care delivery program, which will improve access to the medical services needed to maintain and promote the health status and overall quality of life for the residents of the service area. The new health center will include a 24-hour emergency room and a six-bed short stay nursing unit, and will provide a full range of ambulatory care, as well as, comprehensive community health programs, which will address the curative and preventive health concerns for this region. By constructing one new health center in the demographic center of the region, the maximum number of health care programs can be justified and provided for the user population. The project includes 89 units of staff quarters to provide adequate housing for non-local staff at this remote location.

Existing IHS health care services cannot support the needs of the user population. The proposed new health center will replace the 26 year-old Teec Nos Pos Health Station and the limited contract health services in Montezuma Creek, Utah. Also, the functional inadequacies of existing facilities and site constraints preclude expansion at the existing IHS site.

Health Center in Pawnee, OK: +$10,639,000

Funds in this request will be used to complete construction of the replacement health center in Pawnee, Oklahoma.

The proposed new replacement IHS health center will provide a full range of ambulatory care and community health services to meet the health need s for the residents of the Pawnee Service Area. It will be a more efficient facility, which will enhance the adequacy, access, timeliness, and continuity of a modern health care delivery program.

The IHS and the Pawnee Tribe of Oklahoma have agreed that the existing health center is inadequate to provide a modern health delivery program. The facility, in its present condition, does not comply with current American Institute of Architects "Guidelines for Construction and Equipment of Hospital and Medical Facilities", life safety codes, and barrier-free design standards. There are major concerns with the size and condition of the existing health care facilities and their inability to support a modern health care delivery program. The existing concrete frame and cut stone masonry facility was constructed in 1928 and served as a hospital for the Pawnee Tribe. The hospital was later converted to a health center. From 1936 to 1974, six other structures were constructed to provide support functions to the health center. All seven structures, which house functions such as health care delivery, administration, supply and maintenance, and telephone, are subject to flooding. This factor, plus the physical layout, age, physical plant deficiencies, cost to renovate, and cost of asbestos abatement, underscore the need to provide a replacement health care facility.

Health Center in St. Paul, Alaska: +$11,167,000

Funds in this request will be used to complete construction of the replacement tribal health center in St. Paul, Alaska.

The proposed health care facility will provide laboratory, radiology, emergency and urgent care, ambulatory, community health, dental and pharmacy services for the service population. The staffing will increase from 17 to 34 positions. The new health care facility will provide services for a projected service population of 1,011, with projected

outpatient visits of 10,458. This project includes six units of staff quarters to provide adequate housing for non-local staff at this location.

Existing health care services are being provided under a use permit with the Department of Commerce in three wood frame structures constructed by the U.S. Department of Marine Fisheries Service in 1926, 1929 and 1974. These structures are functionally obsolete and cannot support a modern health care delivery system for the service population.

INDIAN HEALTH FACILITIES CONSTRUCTED SINCE FY 1980

	YEAR COMPLETED	TOTAL APPROPRIATED ($)
Hospitals		
Bethel, AK	1980	34,100,000
Ada, OK	1980	14,374,000
Cherokee, NC	1981	10,341,000
Red Lake, MN	1981	9,566,000
Chinle, AZ	1982	19,758,000
Tahlequah, OK	1983	21,334,000
Browning, MT	1985	15,086,000
Kanakanak, AK	1987	16,578,000
Crownpoint, NM	1987	17,734,000
Sacaton, AZ	1988	15,765,000
Rosebud, SD	1989	20,000,000
Pine Ridge, SD	1993	27,090,000
Shiprock, NM	1995	51,558,000
Crow Agency, MT	1995	23,091,000
Kotzebue, AK	1995	62,483,000
Anchorage, AK	1997	67,915,000
Subtotal		$426,773,000
Health Centers		
Cibecue, AZ	1980	750,000
Lodge Grass, MT	1982	1,485,000
Inscription House, AZ	1983	3,890,000
Ft. Duchesne, UT	1984	2,220,000
Tsaile, AZ	1984	3,856,000
Huerfano, NM	1984	3,304,000
Ft. Thompson, SD	1988	3,449,000
Wolf Point, MT	1990	3,654,000
Kyle, SD	1990	3,209,000
Toppenish, WA	1990	9,350,000
Ft. Hall, ID	1990	6,002,000
Sallisaw, OK	1992	4,265,000
Puyallup, WA	1993	8,472,000
Taos, NM	1993	5,765,000
Wagner, SD	1993	6,119,000
Belcourt, ND (OPD)	1994	19,449,000
Tohatchi, NM	1995	9,279,000
Stilwell, OK	1995	7,663,000
Ft. Belknap, MT		18,885,000
Hays, MT	1997	
Harlem, MT	1998	
White Earth, MN	1998	13,462,000
Lame Deer, MT	1999	14,100,000
Hopi, AZ	2000	34,558,000
Parker, AZ	2001	21,641,000
Subtotal		$204,827,000

INDIAN HEALTH FACILITIES CONSTRUCTED SINCE FY 1980

	YEAR COMPLETED	TOTAL APPROPRIATED ($)
Staff Quarters		
Chinle & Inscription House, AZ (Design)		336,000
Inscription House, AZ (21)	1982	1,764,000
Chinle, AZ (161)	1983	12,236,000
Huerfano, NM (9)	1983	1/
Ft. Duchesne, UT	1984	1/
Crownpoint, NM (36)	1984	3,352,000
Tsaile, AZ (23)	1985	2,141,000
Ft. Thompson, SD (13)	1985	1,279,000
Kanakanak, AK (17)	1986	4,133,000
Browning, MT (26)	1987	2,470,000
Kyle, SD (24)	1987	1,615,000
Supai, AZ (2)	1990	246,000
Rosebud, SD (29 of 66)	1990	7,345,000
Neah Bay, WA (4)	1991	472,000
Dulce, NM (4)	1993	515,000
Barrow, AK (29)	1993	18,183,000
Rosebud, SD (remaining 37 units)	1993	7,695,000
Pine Ridge, SD (45)	1993	9,517,000
Kotzebue, AK (50)	1993	26,155,000
Belcourt, ND (21)	1997	3,912,000
Hopi, AZ (Polacca) (73) 2/	2001	4,995,000
Subtotal		$108,361,000
Youth Regional Treatment Centers		
Alaska - Fairbanks, AK	1933	1,466,000
Alaska - Mt. Edgecumbe, AK	1994	866,000
Phoenix - Sacaton, AZ	1994	2,357,000
Portland - Spokane, WA	1996	7,343,000
Aberdeen - Chief Gall, SD	1996	5,373,000
Subtotal		$ 17,405,000
Joint Venture Demonstration Projects		
Warm Springs, OR	1993	959,000
Poteau, OK	1994	700,000
Subtotal		$ 1,659,000
GRAND TOTAL		$759,025,000

1/ Includes funds reprogrammed from other projects and other facilities accounts.

2/ Hopi Tribe constructed staff quarters with their own funds. $4,995,000 was appropriated to partially fund staff quarters construction so rental rates for IHS staff could be reduced.

FY 2003 Health Care Facilities Construction
Funding Status

FACILITY	PRIOR TO FY 2003 ($000)	FY 2003 BUDGET REQUEST ($000)	TOTAL PROJECT ESTIMATE ($000)
Planning Studies	0	0	1,000
Inpatient Facilities			
Ft. Defiance, AZ	111,971	20,400	132,371
Winnebago, NE	39,670	8,241	47,911
PIMC System, AZ	225	0	299,173
Barrow, AK	0	0	104,324
Nome, AK	0	0	96,222
Outpatient Facilities			
Pinon, AZ	4,527	13,900	40,000
Red Mesa, AZ	7,755	7,653	63,782
Pawnee, OK	6,741	10,639	17,380
St. Paul, AK	2,153	11,167	13,320
Metlakatla, AK	3,448	0	17,269
Sisseton, SD	2,380	0	29,401
Clinton, OK HC	0	0	19,800
Quarters			
Bethel, AK	9,989	0	20,000
Zuni, NM	2,920	0	5,445
Wagner, SD	0	0	2,475
Ft. Belknap, MT	0	0	7,986
Kayenta, AZ	0	0	16,801
Regional Treatment Centers			
PHX-Nevada Satellite	515	0	3,897
S. California YRTC	0	0	6,936
N. California YRTC	0	0	7,117
Joint Venture Construction Program (Sec. 818e)	9,989	0	
Small Ambulatory Care Facility Grants (Sec. 306)	22,491	0	
Dental Program	8,496	0	
Non-IHS Funds Renovation Projects (Sec. 305)	0	0	

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ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Indian Health Service
Indian Health Facilities - 75-0391-0-1-551
Facilities and Environmental Health Support

Program Authorization: Program authorized by U.S.C. 13, Snyder Act, and P.L. 83-568 Transfer Act, 42 U.S.C. 2001.

	2001 Actual	2002 Appropriation	2003 Estimate	Increase Or Decrease
Current Law BA.....	$121,336,000	$126,775,000	$132,963,000	+$6,188,000
Accrued Costs 1/...	5,929,000	6,368,000	6,702,0000	+$334,000
Proposed Law BA....	$127,265,000	$133,143,000	$139,665,000	+$6,522,000
FTE:				
Fac. Sup.....	539	546	561	+15
Envir. Sup.....	440	441	444	+3
OEHE Sup.....	86	86	86	0
Total FTE.....	1,065	1,073	1,091	+18

1/ Please see Exhibit S for the crosswalk from current law to proposed law to reflect the Administration's proposal for full retirement and health benefits.

PURPOSE AND METHOD OF OPERATION

The Indian Health Facilities programs, managed at Indian Health Service (IHS) Headquarters by the Office of Environmental Health and Engineering (OEHE) and carried out by Area, field, and service unit staff, provide an extensive array of real property, health care facilities and staff quarters construction, maintenance, and operation services; as well as community and institutional environmental health, injury prevention, and sanitation facilities construction services. Services are delivered directly by Federal or Tribal employees or by tribal contractors. In addition to staffing costs, funds appropriated for this activity are used to pay for utilities in IHS health care facilities, certain non-medical supplies and personal property, biomedical equipment repair, and some rents. This umbrella account is further managed and distributed through three categories; facilities support, environmental health support, and office of environmental health and engineering support. Currently, costs for permanent positions that constitute the Federal portion of this program are paid from this account. Cost for approximately 197 additional temporary and permanent sanitation facilities construction support personnel are paid from specific sanitation facilities project accounts. Also costs for positions in tribally contracted environmental health activities are included among the permanent positions paid from this account. Costs for health care facilities/staff quarters operation and maintenance personnel are paid from this account or from reimbursements.

The OEHE Headquarters staff includes components in Rockville, Dallas, and Seattle. The staff has management responsibility for IHS facilities and environmental health programs, provides direct technical services and support to Area personnel, and performs critical management functions. Headquarters OEHE management activities include national policy development and implementation; budget formulation; project review and approval; congressional report presentation; quality assurance (internal control reviews, Federal Managers Financial Integrity Act activities, and other oversight); technical assistance (consultation and training for both tribal and IHS personnel); long-range planning; meetings (with Members of Congress and their representatives, with tribes, and with other Federal agencies);

and recruitment and retention. Also, OEHE Engineering Services staff provides architectural, engineering, construction, contracting, and real property services to IHS and tribal health care facilities programs.

There are counterparts of most facilities and environmental health organizational elements in each IHS Area Office. Staff of facilities and environmental health related programs in IHS Area Offices vary in size depending on program scope; the number and size of IHS facilities served; the number, size, and complexity of construction projects; the number and location of Indian communities served; transportation considerations; and the method of providing technical services within the Area. Area facilities and environmental health personnel include architects, engineers, sanitarians, real property and quarter's management specialists, biomedical technicians, facilities planners, injury prevention specialists, construction inspectors, utility operations consultants, draftspersons, and land surveyors.

Area personnel perform local management functions while devoting a predominance of time and effort to providing direct support to service unit, district office, and tribal contracted personnel. Typical of direct support functions are services performed by Area-based technical experts who visit IHS facilities and Indian communities to make institutional (hospital, school, restaurant, water supply) inspections, complete sanitation facilities construction survey work, train water/wastewater treatment plant operators or hospital maintenance personnel, survey real property and IHS staff quarters, perform epidemiological studies of injury occurrences, provide onsite construction inspection services, troubleshoot mechanical/electrical problems in IHS facilities, etc.
The management functions performed by IHS Area personnel parallel those performed by Headquarters but are focused on Area and service unit needs and, therefore, are less broad in quantity and scope. They include Area policy development and implementation, quality assurance in Area/service unit operations (oversight), technical assistance (consultation and training), long-range planning, recruitment, and retention.

District Offices are opened when professional/technical services are needed at two or more IHS health care facilities or sanitation facilities construction projects, which are not large enough to merit full-time staff coverage, when the Area Office is too distant, or when the size of the service area is too large to provide suitable services, oversight, or technical assistance from the Area Office. Currently, IHS has approximately 30 such offices, staffed by engineers, sanitarians, construction inspectors, land surveyors, environmental health and construction technicians, and support personnel. All provide direct program support services.

Funding levels for the last 5 fiscal years follows:

Year	Funding	FTE
1998	$101,617,000	1,192
1999	$107,682,000	1,178
2000	$116,282,000	1,037
2001	$121,336,000	1,065
2002	$126,775,000	1,073

Facilities and Environmental Health Support is divided into three program sub-activities (facilities support, environmental health support, and office of environmental health and engineering (OEHE) support).

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST - The FY 2003 Request of $139,665,000 (including accrued costs of $6,702,000) and 1,091 FTE is a net increase of $6,522,000 and 18 FTE over the FY 2002 Enacted level of $126,775,000 plus accrued cost of $6,368,000 and 1,073 FTE. The increases include the following:

Pay Cost Increases: +$4,211,000

The request of $4,211,000 for Federal and Tribal pay costs would fund the increases associated with on-going operations.

The IHS continues to strive to increase access for the IHS patient population. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between American Indians and Alaska Natives and the rest of the U.S. population.

Accrued Retirement and Health Benefits Costs

The increase of $334,000 is associated with the proposed Managerial Flexibility Act of 2001; **the full accrued cost in FY 2003 for Facilities is $6,702,000.** This legislation requires agencies, beginning in FY 2003, to pay the full Government share of the accruing cost of retirement for current CSRS, CIA and Foreign Service employees, and the Coast Guard, Public Health Service and NOAA Commissioned Corps. The legislation also requires agencies to the pay full accruing cost of post-retirement health benefits for current civilian employees. The intention of the legislation is to budget and present the full costs of Federal employees in the accounts and programs where they are employed. This legislation is part of an initiative to link budget and management decisions to performance by showing the full cost of each year's program operations together with the output produced that year. These accrual costs are shown comparably in FY 2001 and FY 2002.

Phasing-In of Staff for New Facilities: +$2,311,000 and 18 FTE

The request of $2,311,000 and 18 FTE provides for the phasing-in of staff and related costs for new facilities. The staffing of new facilities also contributes to the recruitment and retention of medical staff and promotes self-determination activities.

The following table displays the requested increase.

Facilities:	**Dollars**	**FTE**
Ft. Defiance, AZ Hospital	+$1,651,000	+14
Parker, AZ Health Center	106,000	0
Winnebago, NE Hospital	554,000	4
Total	+$2,311,000	+18

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Indian Health Facilities
Facilities and Environmental Health Support
Facilities Support

	2001 Actual	2002 Appropriation	2003 Estimate	Increase or Decrease
Current Law BA...	$59,907,000	$63,037,000	$66,926,000	+$3,889,000
Accrued Costs 1/.	2,927,000	3,256,000	3,410,000	154,000
Proposed Law BA..	$62,834,000	$66,293,000	$70,336,000	+$4,043,000
FTE.....	539	546	561	+15

1/ Please see Exhibit S for the crosswalk from current law to proposed law to reflect the Administration's proposal for full retirement and health benefits.

PURPOSE AND METHOD OF OPERATION

Funds appropriated for the Facilities Support sub-activity are used to pay certain personnel and operating costs at the Area and Service Unit levels[1]. The personnel paid from this account operate and maintain health care facilities and staff quarters. Staff functions supported by this sub-activity includes management, operation, and maintenance of real property, building systems, medical equipment, and planning and construction management for new and replacement facilities projects. Also, related Area and Service Unit operating costs, such as utilities, building operation supplies, facilities related real and personal property activities, and biomedical equipment repair and maintenance, are paid from this account.

The IHS is committed to ensuring that health care is provided in functional and safe structures. Because many IHS facilities are located in isolated and remote environments far from urban centers, the IHS builds and maintains residential quarters at those locations to house non-local health care personnel.

The IHS owns approximately 853 000 square meters of Federally owned space and 800 hectares of land. The nature of space varies from sophisticated medical centers to residential units and utility plants (see following table). Facilities range in age from less than 1 year to more than 100 years. The average age of our health care facilities is 32 years. Many IHS facilities were built when medicine was practiced much differently than it is today and service populations were much smaller.

1/Costs for these functions performed by P.L. 93-638 contractors at non-Federally-owned or previously Federally-owned facilities are funded from the Services appropriation.

In addition to federally owned space the IHS manages direct lease and GSA assigned space.

Space Occupied by IHS and Tribal Health Care Programs				
Type of Facility	Federally Owned	Direct Federal Lease	GSA Assigned	Tribal
Hospitals and Health Centers	446 655 M^2	89 319 M^2	-0-	208 802 M^2
Staff Quarters	257 173 M^2	5 395 M^2	-0-	*
Other	149 532 M^2	3 996 M^2	61 141 M^2	200 147 M^2
Total	853 360 M^2	98 710 M^2	61 141 M^2	408 949 M^2

- *Tribal Space listed for Hospitals and Health Centers includes all space at locations where direct medical services are provided under P.L. 93-638 contracts in non-IHS owned buildings. Staffing and operations costs (including lease costs) are funded from the Services appropriation.

STAFF FUNCTIONS

Four principal staff functions are funded at the Area and service unit levels through the Facilities Support sub-activity.

- Facilities Engineers

  Area and Service Unit facilities engineers are responsible for ensuring that IHS building systems are operated properly, facilities and grounds are maintained adequately, utilities are managed appropriately, environmental compliance requirements are met, and buildings are safe. The need for maintenance and improvement projects is determined at the Area level and identified in Area Facilities Engineering Plans.

- Clinical Engineers

  The IHS has highly sophisticated medical equipment in its inventory. Skilled, specialized personnel are employed to maintain and service that equipment because the lives of patients and level of patient care depend on accurate calibration and safe operation. Clinical engineers and technicians perform this critically important function. Additional funding to repair biomedical equipment is obtained from Medicare/ Medicaid and private insurance reimbursements. Larger IHS facilities have clinical engineering personnel on-site, but most IHS and tribal facilities depend on Area, district, or service unit-based clinical engineers and technicians, who travel to several facility locations, to repair and maintain biomedical equipment.

- Real Property Management

  Realty Officers provide technical and management assistance for realty activities associated with direct-leased, GSA-assigned, and IHS-owned (and to some degree tribally-owned) space. The program includes facility and land acquisitions and disposals, licensing/easement processing, use-permit issuance, quarters management and rent setting

activities, lease administration, and budget functions. The program also helps tribes and tribal organizations acquire, administer, and/or manage excess federally owned and tribally leased real property.

- Facilities Planning and Construction

  Some IHS Areas have facilities planning and construction-monitoring components that assist in the planning and construction management of new and replacement health care facility and staff quarters projects. The need for new facilities is determined by applying the IHS Health Facilities Construction and Quarters Construction Priority System methodologies. Area staffs develop initial proposals for new and replacement facilities, prepare Program Justification Documents, Program of Requirements Documents, and Project Summary Documents for projects. While construction is underway, Area facilities management staff may be supplemented with construction management personnel to oversee Federal interests in the construction of new and replacement facilities.

OPERATION COSTS

- Utility Costs

  Utility costs include heating and air conditioning expenses, fuel oil, natural gas, propane, water, sewer, and electricity for lighting and equipment operation.

- Building Operation Supplies and Equipment

  Funds for building operation supplies and equipment, such as, special tools to perform maintenance, heating and air conditioning supplies, etc.

- Biomedical Equipment and Repair

  The clinical engineering program provides technical service and support for biomedical equipment at IHS and tribal health care facilities. The program also administers service contracts for biomedical maintenance and repair, where clinical engineering personnel are not available to perform this service.

- Leased Space

  The IHS continues to apply its Lease Priority System (LPS) methodology in order to plan/budget for federally funded IHS and tribal program space. The LPS improves lease management by establishing specific criteria for evaluating Federal and tribal health program space requests.

All lease costs are paid from the Services appropriation.

Funding levels for the last 5 fiscal years follows:

Year	Funding	FTE
1998	$48,219,000	560
1999	$53,857,000	580
2000	$56,990,000	535
2001	$59,907,000	539
2002	$63,032,000	546

ACCOMPLISHMENTS

In FY 2001, Facilities Support provided Area offices and service units with staff to operate and maintain the health care buildings and grounds, and to service medical equipment. This responsibility includes an inventory of approximately $310 million of medical equipment, hospitals, health centers, staff quarters, smaller health stations and satellite clinics, school health centers, and youth regional treatment centers. IHS will continue these functions in FY 2003.

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST - The FY 2003 Request of $70,392,000 (including accrued costs of $3,466,000) and 561 FTE is a net increase of $4,043,000 and 15 FTE over the FY 2002 enacted level of $63,037,000 plus accrued cost of $3,256,000 and 546 FTE. The increases include the following:

Pay Cost Increases: +$1,951,000

The request of $1,546,000 for Federal and Tribal pay costs would fund the increases associated with on-going operations.

The IHS continues to strive to increase access for the IHS patient population. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between AI/ANs and the rest of the U.S. population.

Accrued Retirement and Health Benefits Costs

The increase of $210,000 is associated with the proposed Managerial Flexibility Act of 2001; **the full accrued cost in FY 2003 for Facilities is $4,099,000.** This legislation requires agencies, beginning in FY 2003, to pay the full Government share of the accruing cost of retirement for current CSRS, CIA and Foreign Service employees, and the Coast Guard, Public Health Service and NOAA Commissioned Corps. The legislation also requires agencies to the pay full accruing cost of post-retirement health benefits for current civilian employees. The intention of the legislation is to budget and present the full costs of Federal employees in the accounts and programs where they are employed. This legislation is part of an initiative to link budget and management decisions to performance by showing the full cost of each year's program operations together with the output produced that year. These accrual costs are shown comparably in FY 2001 and FY 2002.

Phasing-In of Staff for New Facilities - +$2,092,000 and +15 FTE

The request of $2,092,000 and 15 FTE provides for the phasing-in of staff and related costs for new facilities. The staffing of new facilities also contributes to the recruitment and retention of medical staff and promotes self-determination activities. The following table displays the requested increase.

Facilities	Dollars	FTE
Ft. Defiance,AZ Hospital	$1,432,000	+11
Parker,AZ Health Center	106,000	-0-
Winnebago, NE Hospital	554,000	+ 4
Total	$2,092,000	+15

Indian Health Facilities
Facilities and Environmental Health Support
Environmental Health Support

	2001 Actual	2002 Appropriation	2003 Estimate	Increase or Decrease
Current Law BA...	$50,997,000	$52,857,000	$54,793,000	+$1,936,000
Accrued Costs 1/.	2,492,000	2,629,000	2,778,000	149,000
Proposed Law BA..	$53,489,000	$55,486,000	$57,571,000	+$2,085,000
FTE.....	440	441	444	+15

1/ Please see Exhibit S for the crosswalk from current law to proposed law to reflect the Administration's proposal for full retirement and health benefits

PURPOSE AND METHOD OF OPERATION

Funds in the Environmental Health Support sub-activity are used to pay for personnel who accomplish environmental health services, injury prevention activities, and sanitation facilities construction activities, at the IHS Area, district, and service unit levels and operating costs associated with provision of those services and activities.

Most American Indian and Alaska Native (AI/AN) people live in environments typified by severe climatic conditions, rough, often treacherous geography, extreme isolation, infestations of disease carrying insects and rodents, limited and sub-standard housing, unsanitary methods of sewage and garbage disposal, and unsafe water supplies. Such harsh environments, coupled with decades of economic deprivation and compounded by the lack of basic environmental essentials in many homes (such as running water and toilet facilities) historically have contributed significantly to the exceptionally high incidence of disease, injury, and early death among the AI/AN people.

Developing solutions to the many environmental concerns affecting AI/ANs requires knowledge and expertise possessed by a variety of professional and technical environmental health and skilled health specialists. The Area, district and service unit environmental health staffs include engineers, sanitarians, environmental health technicians, engineering aides, injury prevention specialists, and institutional environmental control officers.

PROGRAM EMPHASIS AREAS

- General Environmental Health

  Concurrent with the provision of technical and consultative environmental health services, Area, district and service unit environmental health services staff provide a wide range of technical services to American Indian and Alaska Native communities including water quality, waste disposal, hazardous materials management, food sanitation, institutional environmental health, vector control, and occupational safety and health. A critical component of this effort is the provision of technical assistance to the Tribes in developing environmental health program management capacity.

  Starting in FY 2002, the Environmental Health Services program will utilize the Web-based Environmental Health Reporting System (WebEHRS) in conjunction with Tribal partners to collect community and facility information to be used for ongoing surveillance. At the regional

level, this project will be coordinated with the IHS Area Environmental Health Officers in partnership with the tribes and local IHS Environmental Health Services programs.

The collection, organization, and implementation of environmental health and epidemiological data may redesign the services and activities currently provided by and recommended by the Environmental Health Services program. Data analysis is necessary to establish baseline levels of community environmental health, evaluate the effectiveness of existing programs and to plan future programs to ensure that resources and activities are best targeted to most effectively reduce environmentally related disease and injury at the local level.

- Injury Prevention

  Injuries have a significant, adverse effect on AI/AN populations. Between 1994 and 1996, over 5,000 AI/AN residing in the IHS service area, died from unintentional injuries (motor vehicle crashes, home fires, drowning, poisoning, etc.). Also, intentional injuries such as suicide and homicide average almost 1,700 AI/AN deaths per year.

  On average, AI/ANs are dying at a rate 2.5 times the U.S. All Races rate for injuries and poisonings. The rates for Aberdeen and Navajo Areas were 3.3 times the U.S. All Races rate. The rate for Alaska was 3.5 times the U.S. All Races rate. The IHS estimates conservatively that $150,000,000 is spent each year on transportation and acute care of injured Indian people; however, costly critically needed re-constructive surgeries, prosthetic devices, and rehabilitative services often cannot be provided. Frequently overlooked is the effect that injuries have on the injured person's family. Severe disabling injuries often affect the financial and social fabric of the family and the community, causing a "burden" unparalleled by other health problems.

  For many years the IHS has been aware of the significant drain on its limited health care resources that is caused by stabilizing, transporting, treating, and rehabilitating injury victims. In 1981, an Injury Prevention Program was initiated within the environmental health activity. Early efforts by Area, district, and service unit personnel at improved surveillance and targeted intervention were so encouraging that a formal injury prevention training program was established.

  One of the most important advancements in the field of injury prevention was dispelling the myth that injuries were a result of uncontrollable events. In fact, today it is known that injuries are predictable occurrences that can be successfully prevented with properly targeted interventions. There is quantitative evidence that community-based prevention programs, patterned on the public health model, can reduce the incidence of severe injuries requiring hospitalization.

  For instance, when Centers for Disease Control and Prevention personnel evaluated the effect of the Navajo Nation's motor vehicle safety belt law, they found that the number of severe injuries attributable to motor vehicle crashes was reduced by 28 percent. This reduction represents estimated savings to the Federal Government of more than $2,000,000 in direct care expenditures alone. An analysis of deaths among Alaska Natives in the Yukon River delta region indicated 30 percent reduction in drowning deaths. This

reduction is attributed to a 5-year drowning prevention education effort sponsored by the Yukon Kuskokwim Health Corporation's Injury Prevention Program.

The IHS Five-Year Injury Prevention Strategic Plan identified the need for basic capacity building and investments in tribal and Federal infrastructures for the development of effective injury prevention programs. Since 1990, Congress has appropriated over $5.3 million to injury prevention programs and competitively based intervention projects. In 1997 the Director, IHS, supported a national demonstration grant announcement for basic public health infrastructure projects within tribes. Approximately $300,000 was awarded for 12 tribal project sites. In addition to these projects, literally hundreds of Indian communities and Alaska Native villages implemented proven injury prevention strategies associated with safe home and communities.

IHS has applied a community capacity building approach with the intent of developing the local public health capacity of tribes to significantly reduce injuries in their communities' settings. This systematic process includes training, core-funding base, partners, implementing interventions, and technical assistance as needed. These efforts have contributed to a 54 percent reduction all injury related deaths between 1972 and 1996. In FY 2000, IHS awarded approximately $1.25 million dollars to tribes to establish comprehensive injury prevention programs. These 25 new programs are receiving $50,000 per year for 5 years to hire a full time injury prevention coordinator, form an injury prevention advisory group, conduct basic injury surveillance, form partnerships, and begin to implement strategies to target those at risk for injuries.

Also, IHS has developed injury prevention training programs specifically for the community-based practitioner. To support tribal capacity building, IHS provides technical training in the area of community injury prevention to approximately 100 tribal health personnel annually through the three Injury Prevention Practitioner courses. Since 1987, 58 of the 178 students (48%) who have successfully completed the Injury Prevention Specialist Fellowship Program are American Indians or Alaska Natives. This program is a year-long course of study in advanced injury prevention.

Support for the IHS Injury Prevention Program is found in the Indian Health Care Improvement Act (Public Law 94-437) and in Healthy People 2010, which is the prevention agenda for the nation. Injury and Violence Prevention have been grouped as one of the 10 leading health indicators. Thirty-one objectives relate to injury or unintentional injury prevention.

- Institutional Environmental Health

  Institutional Environmental Health (IEH) specialists, where available on IHS staffs, work with managers of health care, educational, childcare, and correctional facilities. Such institutions have diverse clientele but share many common problems (such as risks and hazards of new technologies). Emerging disease risks and hazards, stricter regular requirements and escalating costs resulting from claims for compensation for work related injuries sustained by health care workers make institutional environmental problems ever more complexing and challenging.

The IEH specialists are trained to anticipate, recognize, and evaluate potential hazards and recommend control procedures. Periodic, formal evaluations of institutions serving AI/AN populations are performed in order to assess environmental conditions, identify those that may cause adverse health effects, and make recommendations to prevent or minimize harm. Among operational areas of interest to IEH specialists are as follows: infection control, industrial hygiene, radiation protection, safety management, and general environmental health conditions.

Assistance is provided to institution managers/operators in developing appropriate program for protecting clients and employees, and in complying with legislation and executive orders regarding environmental health and safety management issues. Advice is also offered regarding compliance with accreditation and/or certification standards. Maintaining accreditation ensures that IHS continues to have access to third-party funding.

An evaluation research grant of $116,000 was funded for FY 1997. This joint initiative conducted by the Office of Environmental Health and Engineering and the Office of Public Health was intended to evaluate the effect of primary prevention and case management in reducing the incidence and associated costs of work place injuries. The program targeted the 25 largest IHS hospitals and 4 hospitals associated with self-governance tribes. Grant funds were used to purchase injury tracking software, interactive safety training software, occupational rehabilitation training, and reference materials, as well as provide funds for special projects and bio-statistical support.

- Sanitation Facilities Construction

  In accordance with P.L. 86-121, Indian Sanitation Facilities Act, the IHS manages and provides professional engineering and services to construct over 450 projects annually, at a total cost of over $138 million, to provide essential sanitation facilities for AI/ANs. This work is a significant component of the comprehensive environmental health services provided by Area, district and service unit environmental health personnel. These services include management of staff, pre-planning consultation with tribes and tribal groups, coordination with other federal, state and local governmental entities, identifying supplemental funding outside of IHS, developing local policies and guidelines with tribal consultation, developing agreements with tribes and others for each project, providing project design and construction, assuring environmental and historical preservation procedures are followed, assisting tribes where the tribes provide construction management, and assisting tribes with operation and maintenance of constructed facilities. All of these activities are made more difficult due to the remote locations where they work, the diverse climatic and geologic conditions, and cultural considerations. The Sanitation Facilities Construction program assures that its staff is highly qualified for its mission by requiring professional licensure of District Engineers and higher-level positions.

  In accordance with the Indian Health Care Improvement Act (Title III, Section 302(g) 1 and 2 of P.L. 94-437) the IHS annually updates its inventory of sanitation facilities deficiencies for existing Indian homes. This is carried out in considerable consultation with tribes. The IHS also develops and updates an inventory of all open dump sites on Indian lands as required under the Indian Lands Open Dump Cleanup

Act (P.L. 103-399). Both of these inventories are widely used by other governmental agencies in their evaluations and funding of sanitation projects.

Once a sanitation facility is built, the Indian family and/or community for which it was constructed assume operation and maintenance responsibilities including payment of associated costs. Therefore, a primary responsibility of IHS Area, district and service unit environmental health personnel is to provide technical assistance and guidance to Indian families and communities regarding the operation and maintenance of essential water supply and sewage disposal facilities.

Where appropriate, IHS environmental health personnel provide technical assistance to tribes and communities to create and manage sanitation facility operation and maintenance organizations. Among other areas, the IHS provides facility maintenance training and assistance with establishing ordinances and user fee schedules. The availability of technical assistance from IHS has contributed significantly to the ability of the small communities and rural families to keep their facilities in working condition. Sustained attention to proper operation and maintenance of these facilities, by tribes, communities, and individual homeowners, is an important contribution to continued strengthening of community infrastructure for AI/AN. In addition, it is necessary to protect the enormous preventive health investment made by the Federal Government on behalf of AI/AN.

TRIBAL HEALTH PROGRAMS

The IHS Area, district and service unit environmental health personnel also train tribal employees to provide environmental health services, under contract with IHS wherever a tribe desires, provided that funds are available and other considerations make such arrangement practicable. As a result of training provided by IHS, tribal environmental health personnel are better prepared to provide higher levels of service to the Indian people and to support the provision of direct patient care services. For example, some tribes have chosen to contract for the provision of the full range of environmental health services as typically provided by the IHS direct delivery program.

The tribes have been an integral part of the sanitation facilities program for years. In recent years they have administered more than 50 percent of the project funds for the provision of sanitation facilities to AI/AN homes and communities. A Navajo tribal enterprise, the Navajo Engineering and Construction Authority, exemplifies this successful effort. It constructs virtually all sanitation facilities provided by the IHS on the Navajo Indian Reservation and employs approximately 350 Navajos on IHS funded construction projects.

Area, district and service unit environmental health personnel work with tribes/tribal organizations to encourage maximum participation in planning health services delivery programs. Also, they provide technical assistance to the tribal officials who carry out administrative/management responsibilities associated with operation of federally supported programs. Their support of self-determination for tribal organizations will continue. However, the extent to which there is participation in the self-determination process depends on, and is determined by, the individual tribes/tribal organizations.

Funding levels for the last 5 fiscal years follows:

Year	Funding	FTE
1998	$42,463,000	550
1999	$44,548,000	503
2000	$49,162,000	440
2001	$50,997,000	440
2002	$52,857,000	441

ACCOMPLISHMENTS

Environmental Health Support - The FY 2001 accomplishments are as follows: (1) Managed 3,396 active projects to construct sanitation facilities (2) Worked with other agencies to secure additional funding (3) initiated projects to provide sanitation facilities for 483 HUD housing units, 227 Bureau of Indian Affairs units, 2,841 other new housing units, and 14,451 existing housing units; (3) Funded 25 tribes to create injury prevention programs managed by full-time staff, 4) Implemented a web-based facility data collection system that is used by 175 IHS and tribal environmental health staff and tracks 19,052 environmental health services and facilities, and 5) performed environmental health services.

Performance Measures

The following performance indicator is included in the IHS 2003 Annual Performance Plan. These indicators are sentinel indictors representative of some of the more significant health problems affecting AI/AN. At the FY 2003 funding level, IHS could achieve the following:

Indicator 25: During FY 2003, maintain the number of tribes/tribal organizations that meet the criteria standards of IHS comprehensive injury prevention programs at the FY 2002 level.

Indicator 33: During FY 2003, the IHS will increase the number of active tribal user accounts for the automated Web-based environmental health surveillance system by 15% over the FY 2002 level for American Indian and Alaska Native tribes not currently receiving direct environmental health services.

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST - The FY 2003 Request of $57,571,000 (including accrued costs of $2,778,000) is a net increase of $2,085,000 and 3 FTE over the FY 2002 enacted level of $52,857,000 plus accrued cost of $2,778,000 and 441 FTE. The increases include the following:

Pay Cost Increases: +$1,866,000

The request of $1,866,000 for Federal and Tribal pay costs would fund the mandatory increases associated with on-going operations.

The IHS continues to strive to increase access for the IHS patient population. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between American Indians and Alaska Natives and the rest of the U.S. population.

Phasing-In of Staff for New Facilities: +$219,000 and +3 FTE

The request of $219,000 and 3 FTE provides for the phasing-in of staff and related costs for new facilities. The staffing of new facilities also contributes to the recruitment and retention of medical staff and promotes self-determination activities. The following table displays the requested increase:

Facilities	Dollars	FTE
Ft. Defiance, AZ Hospital	$219,000	+3

Accrued Retirement and Health Benefits Costs

The increase of $148,000 is associated with the proposed Managerial Flexibility Act of 2001; **the full accrued cost in FY 2003 for Facilities is $2,737,000.** This legislation requires agencies, beginning in FY 2003, to pay the full Government share of the accruing cost of retirement for current CSRS, CIA and Foreign Service employees, and the Coast Guard, Public Health Service and NOAA Commissioned Corps. The legislation also requires agencies to the pay full accruing cost of post-retirement health benefits for current civilian employees. The intention of the legislation is to budget and present the full costs of Federal employees in the accounts and programs where they are employed. This legislation is part of an initiative to link budget and management decisions to performance by showing the full cost of each year's program operations together with the output produced that year. These accrual costs are shown comparably in FY 2001 and FY 2002.

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Indian Health Facilities
Facilities and Environmental Health Support
Office of Environmental Health and Engineering Support

	2001 Actual	2002 Appropriation	2003 Estimate	Increase or Decrease
Current Law BA....	$10,432,000	$10,881,000	$11,244,000	+$363,000
Accrued Costs 1/..	510,000	483,000	514,000	31,000
Proposed Law BA...	$10,942,000	$11,364,000	$11,758,000	+$394,000
FTE.....	86	86	86	--

1/ Please see Exhibit S for the crosswalk from current law to proposed law to reflect the Administration's proposal for full retirement and health benefits

PURPOSE AND METHOD OF OPERATION

FY 2002 Base

The Office of Environmental Health and Engineering Support sub-activity funds personnel and operating costs for the Office of Environmental Health and Engineering (OEHE) Headquarters.

Headquarters personnel have management responsibility for IHS facilities and environmental health programs, provide direct technical services and support to Area personnel and perform critical management functions. Headquarters management activities includes national policy development and implementation; budget formulation; project review and approval; congressional report preparation; quality assurance (internal control reviews, Federal Managers Financial Integrity Act activities and other oversight); technical assistance (consultation and training); long range planning; meetings (with Members of Congress and their representatives, with tribes, and with other Federal agencies); and recruitment and retention. Typical direct support functions performed by OEHE personnel who serve as project officers for health facilities construction projects are: to review and/or write technical justification documents, participate in design reviews and site surveys, conduct onsite inspections, and monitor project funding status.

The OEHE Headquarters funded positions are in Rockville, Dallas, and Seattle. Headquarters personnel include engineers, sanitarians, health facilities planners, real property managers, and support personnel. Also, Engineering Services staff located in Dallas and Seattle provides architectural, engineering, construction services, contracting services, and real property services. They provide direct services and support to other Headquarters Division and Area personnel in preparing the project justifications, construction cost estimates, and project designs, contracting for design and construction of new health care facilities and existing facility improvements, conducting construction inspections and facility inspections; leasing space for IHS program operations; and providing management support.

Funding levels for the past 5 years are as follows:

Year	Funding	FTE
1998	$10,935,000	110
1999	$9,277,000	95
2000	$10,130,000	62
2001	$10,432,000	86
2002	$10,881,000	86

ACCOMPLISHMENTS

In FY 2001, this subactivity funded personnel who have management responsibilities for National policy development and implementation, budget formulation, congressional report preparation, health care facilities construction and other national program related duties. The OEHE Division of Engineering Services (ES) completed the construction of 1 health center, 2 health stations, and 25 maintenance & improvement projects. Thirty-seven new leases and 45 existing leases were modified. The ES managed 92 contracts worth $243 million and awarded 40 contracts worth $25 million. Also, 7 construction-related surveys were completed.

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST - The FY 2003 Request of $11,743,000 (including accrued costs $514,000) is a net increase of $394,000 over the FY 2002 enacted level of $10,881,000 plus accrued cost of $483,000 and 81 FTE. The increases include the following:

Pay Cost Increases: +$394,000

The request of $394,000 for Federal and Tribal pay costs would fund the increases associated with on-going operations.

The IHS continues to strive to increase access for the IHS patient population. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between AI/ANs and the rest of the U.S. population.

Accrued Retirement and Health Benefits Costs

The increase of $16,000 is associated with the proposed Managerial Flexibility Act of 2001; **the full accrued cost in FY 2003 for Facilities is $379,000**. This legislation requires agencies, beginning in FY 2003, to pay the full Government share of the accruing cost of retirement for current CSRS, CIA and Foreign Service employees, and the Coast Guard, Public Health Service and NOAA Commissioned Corps. The legislation also requires agencies to the pay full accruing cost of post-retirement health benefits for current civilian employees. The intention of the legislation is to budget and present the full costs of Federal employees in the accounts and programs where they are employed. This legislation is part of an initiative to link budget and management decisions to performance by showing the full cost of each year's program operations together with the output produced that year. These accrual costs are shown comparably in FY 2001 and FY 2002.

ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Public Health Service - Indian Health Service
Indian Health Facilities - 75-0391-0-1-551
Equipment

	2001 Actual	2002 Appropriation	2003 Estimate	Increase or Decrease
Budget Authority..	$16,294,000	$16,294,000	$16,294,000	$0

PURPOSE AND METHOD OF OPERATION

The IHS manages approximately $310,000,000 in laboratory, x-ray, and biomedical equipment. Accurate diagnosis and effective therapeutic procedures depend in large part on clinicians using modern and effective medical equipment to assure the best possible health outcomes. The average life expectancy for the current medical inventory is approximately 6 years depending on the intensity of use, maintenance and technical advances. In addition, this activity funds equipment for replacement clinics built by Tribes using non-IHS funding sources, replacement of ambulances, and the transfer of available excess Department of Defense medical equipment to IHS and Tribal health programs.

Funding levels for the last 5 fiscal years follows:

Year	Funding
1998	$13,005,000
1999	$13,243,000
2000	$14,330,000
2001	$16,294,000
2002	$16,294,000

Accomplishments

In FY 2001, (1) The equipment program distributed approximately $10 million to existing health care facilities to replace and purchase new medical equipment; (2) A total of approximately $5 million to equip new health care facilities being funded with non-IHS funds was apportioned to tribal applicants; and (3) implemented a biomedical device management system.

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST -- The request of $16,294,000 is a same level as the FY 2002 Enacted level of $16,294,000.

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ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Public Health Service - Indian Health Service
Indian Health Facilities - 75-0391-0-1-551
Personnel Quarters/Quarters Return Funds

	2001 Actual	2002 Appropriation	2003 Estimate	Increase or Decrease
Reimbursements..	$5,500,000	$5,700,000	$5,900,000	$200
FTE.....	47	47	47	--

PURPOSE AND METHOD OF OPERATION

FY 2002 Base

Staff quarter's operation, maintenance, and improvement costs are funded with Quarters Return (QR) funds. In certain situations, M&I funds may be used, in conjunction with QR funds, to ensure adequate quarters maintenance; e.g., locations with few quarters where QR funds are not enough to pay for all required maintenance costs. Approximately $5,900,000 in QR funds will be collected during FY 2003. These funds will be used for the operation, management, and general maintenance of quarters, including temporary maintenance personnel, security guards, repairs to housing units and associated grounds, and purchase of materials, supplies, and household appliances/equipment (stoves, water heaters, furnaces, etc.).